RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

CHAPTER 1200-11-3
CHILDREN'S SPECIAL SERVICES

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1200-11-3-.01 STATEMENT OF PURPOSE.

(1) In an effort to provide more comprehensive services to children with special health care needs in Tennessee, the Department of Health merged the Crippled Children's Services and the Speech and Hearing Services into one unit and implemented care coordination services to children enrolled in the program in 1992. The program was then identified as the Children's Special Services (CSS) program. The implementation of the TennCare managed care system with the resulting enrollment of previously non-Medicaid eligible CSS population requires the Department to redefine the CSS program's medical and financial eligibility, provider network, covered services, and reimbursement methods. Children with special health care needs, especially those who are uninsured now have access to insurance through TennCare. The program recognizes the need to serve a broader group of children with special health care needs who meet the T.C.A 68-12-102 definition of "physically handicapped". Program resources will provide for diagnostically related necessary services for enrolled children when other payors will not provide coverage.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*

1200-11-3-.02 DEFINITIONS. Unless otherwise specifically indicated by the context, for the purpose of these rules and regulations, the terms used herein are defined as follows.

(1) Assistive Technology/Augmentative Communication Devices - Any device or equipment that may promote independence and communication skills for children unable to utilize typical methods for independence.

(2) Care Coordination/Case Management - Services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.

(3) Commissioner - The Commissioner of the Tennessee Department of Health or the Commissioner's designee.

(4) Department - The Tennessee Department of Health.

(5) Diagnostic Condition - Diagnoses specifically designated by the program as conditions qualifying a child for program eligibility.

(6) Diagnostic Evaluation - Physical examinations, medical procedures, laboratory tests, or other procedures deemed necessary for diagnosis.

(7) Durable Medical Equipment - Durable Medical Equipment means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home. Orthotics, Prosthetics, and Communication Aid Devices are also included in the definition of "Durable Medical Equipment".

(8) Elective Hospital Admission - Any hospital admission for conditions or treatments not immediately necessary to save the patient's life or prevent impending harm.

(9) Family - For the purpose of the CSS program, a family is defined as follows:

(a) Two or more persons related by birth, marriage, or adoption, which reside together. (If a household includes more than one family, the guidelines are applied separately to each family.)

(b) A person eighteen (18) years of age or older who is not living with any relative;

(c) A child under eighteen (18) years of age and his/her non-parent custodians when financial responsibility has been assigned to them by the court; or

(d) Parents of a child under eighteen (18) years of age when the child has been voluntarily placed outside the parent's home.

(10) Hospitalization - Any overnight stay in a hospital capable of providing the type of service(s) needed by the child and licensed pursuant to applicable regulations and/or statutes.

(11) Inpatient Hospital Services - Medical and surgical services (including screening, diagnostic, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including room and board) provided during hospitalization in a licensed hospital.

(12) Medical Services - Medical, surgical, and rehabilitative treatment for conditions related to an approved diagnostic condition.

(13) Medically Related Services - Services deemed necessary to follow the treatment plan for an approved medical condition.

(14) Orthodontic/Dental Intervention - Medical, surgical, and rehabilitative treatment for conditions related to an approved cranial-facial diagnostic condition.

(15) Outpatient Hospital Services - Medical and surgical services (including screening, diagnostic, therapeutic, corrective, preventive, and palliative services) and facility usage charges (including temporary room and board) provided as an outpatient service by a licensed hospital or hospital-based Ambulatory Surgical Treatment Center.

(16) Outpatient/Clinic Services - Diagnostic evaluation or treatment services delivered in a public or private setting outside of the hospital.

(17) Pharmaceuticals and Supplies - Medications and supplies necessary for treatment related to a diagnostic condition covered by the program.

(18) Physically handicapped or crippled child - A child under the age of twenty-one (21) who shall be deemed "chronically handicapped" by any reason of physical infirmity, whether congenital or acquired, as a result of accident or disease, which requires medical, surgical, dental, or rehabilitation treatment, and who is or may be, totally or partially incapacitated for the receipt of a normal education or for self support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic. This definition

does not prohibit CSS from accepting for treatment children with acute conditions such as, but not necessarily limited to, fractures, burns and osteomyelitis.

(19) Provider - A person, persons, or facility giving direct service to the child as outlined in the child's plan of treatment.

(20) Rehabilitation - Services required to assist the individual to achieve or maintain independence. Rehabilitative services may include physical, speech/language, nutritional/feeding, and occupational therapies.

(21) Resident of Tennessee - A person who has established a bona fide residence in Tennessee. The test for such residence is (1) an intention to stay indefinitely in a place, joined with (2) some objective indication consistent with that intent, e. g., enrollment of a child in school.

(22) Support Services - Activities that may be necessary to assist the individual or family to access medically necessary and/or recommended care to participate in the activities of daily living.

(23) TennCare - The State of Tennessee Medicaid Waiver program that replaced the State's Medicaid program. The TennCare Bureau contracts with managed care organizations (MCOs) to provide a network of providers to serve TennCare enrolled children.

(24) Third Party Payor - The payment for health care by a party other than the beneficiary.

(25) Title V Children with Special Health Care Needs (CSHCN) - The Federal Title V CSHCN section of the Title V Maternal and Child Health CSHCN Block Grant that supports the program.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Amendment filed December 7, 1998; effective April 30, 1999. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*

1200-11-3-.03 ELIGIBILITY REQUIREMENTS.

(1) Any child from birth to twenty-one years of age who is a resident of Tennessee will be deemed eligible for medical services, medically related services, and care coordination through the CSS program provided the child meets the diagnostic and financial guidelines as established by the program.

(2) Any child from birth to twenty-one years of age who is a resident of Tennessee and enrolled in TennCare will be deemed eligible for care coordination (case management) services, provided the child meets the diagnostic guidelines as established by the program and staff are available to provide these services.

(3) Any child with a diagnosis of cystic fibrosis can remain on the program past the age of 21 years until their demise.

(4) Financial eligibility will be determined based on an amount equal to, or a percentage rate above, the Federal Poverty Guidelines as published annually in the Federal Register. Children will be eligible if the family income is at or below 200% of poverty, for the number in the family. When a family has more than one (1) child with an eligible condition, one person may be added to the total number of family members when determining eligibility. Family is defined in Rule 1200-11-3-. 02.

(a) Income shall include:

1. wages, salaries, and/or commissions;

2. income from rental property or equipment;

3. profits from self-employment enterprises, including farms;

4. alimony and/or child support;

5. inheritances;

6. pensions and benefits; and

7. public assistance grants.

(b) After the gross monthly income of the family is determined, it may be adjusted for the following:

1. verification of medical payments including medical or health insurance premiums made by the family for any family member during the previous twelve (12) months. The amount of such payments shall be prorated over twelve (12) months and deducted from the gross monthly income.

2. verification of child support or alimony paid to another household which shall be deducted from the gross monthly income.

(5) The family's adjusted gross monthly income must be at or below 200% Federal Poverty Level, (FPL) in effect at the time of application for program enrollment. Enrolled children will be re-certified annually.

(a) Re-certification by TennCare for children enrolled in TennCare, will be accepted as re-certification for this program. In the event that TennCare does not re-certify enrollees for a period of time, CSS will re-certify children every two years. Children with TennCare coverage who are enrolled in CSS will continue in the program until their status with TennCare changes or maximum treatment has been reached for eligible diagnosis.

(b) Children with private insurance coverage will be re-certified annually by the program.

(c) Children without insurance coverage who meet the financial and diagnostic guidelines will be enrolled in the program and assisted with application for TennCare.

(6) The child's medical diagnosis may determine the level of financial or supportive services provided by the program.

(7) As a condition of eligibility, children who have access to other health insurance whose family has income below 200% FPL must apply for coverage under TennCare. In the event that a child is then covered and also enrolled in the program, the CSS program will be the payor of last resort and coordinate benefits.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*

1200-11-3-.04 COVERED SERVICES.

(1) Covered services are those described in Rule 1200-11-3-.02 that are not covered by other payors and are limited to those that directly relate to the diagnostic condition which made the child eligible for the program. Covered services may include: inpatient hospitalization; outpatient hospitalization or clinic services; care coordination services; orthodontic/dental intervention; pharmaceuticals and supplies such as medication, nutritional supplements, other supplies; durable medical equipment; rehabilitative therapies, assistive technology/augmentative communication devices, co-pay and deductibles; or other support services as determined by the Commissioner and the program. This benefit may include rental or purchase of durable medical equipment; maintenance, repair, or replacement of durable medical equipment; and, where appropriate, training of the enrollee or the enrollee's family in the use of the equipment. For children with other insurance payors, those resources will be exhausted before the program considers payment. Any payment for services will conform to policies and procedures of the CSS program.

(2) Services not covered.

(a) Transplant surgeries will not be covered. Drugs and supplies directly related to the transplant will also not be covered.

(b) Drug treatments will not be reimbursed unless the drug is FDA approved for the purpose intended.

(c) Dental and Orthodontic treatment will not be covered except in craniofacial malformations, cleft palate conditions, and designated cardiac conditions as outlined in program policy.

(d) Psychiatric treatment and psychological services will not be covered.

(e) Alcohol and drug treatment will not be covered.

(f) Ambulance fees and transportation will not be covered except for emergency transportation from one hospital to another.

(g) Children admitted to a nursing home for continuous or episodic care will not be covered for CSS services until discharged.

(3) The type and amount of covered services will be determined by the availability of funds. When budgetary constraints are indicated, the department may:

(a) create a waiting list of patients requesting elective hospital admissions. (The waiting list will be evaluated on a monthly basis and elective admissions will be approved according to availability of funds.);

(b) eliminate in-patient hospitalization services as defined in 1200-11-3-.02, except for life-threatening conditions and conditions that would cause a permanent disability, if not treated immediately;

(c) eliminate services for less severe diagnostic categories as designated by the program; or

(d) reduce the type and amount of support services, durable medical equipment, care coordination, or other covered services.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*

1200-11-3-.05 AUTHORIZATION AND REIMBURSEMENTS.

(1) Except for applicable deductibles, co-insurance, and/or co-payment, no reimbursement shall be made for covered services rendered under these rules, unless available third party payors, such as TennCare or private insurance, have been exhausted.

(2) After all third party payors have been exhausted, or in the event no third party payors are available, reimbursement for covered services shall be in accordance with these rules.

(3) Services must be authorized by the CSS program for reimbursement and must relate to the diagnosis for which the child is eligible for the program.

(4) Additional and concurrent charges over and above the amount covered by third party payors, as provided in these rules, shall not be submitted to the family. This does not preclude a family or other party from making a contribution toward the care of the child when they are willing and able but such contributions shall not be solicited or accepted from the family of a child on TennCare for services covered in whole or in part by TennCare.

(5) Reimbursement.

(a) Reimbursement for inpatient hospitalization and rehabilitation services shall be based on a per diem rate as negotiated between the Department and the facility.

(b) Reimbursement for covered medical services shall be based on:

1. Average wholesale price for pharmacy plus a $4.00 shipping and handling fee.

2. For medical services, on an annual basis the required minimum reimbursement rate shall be updated to the equivalent of the prior year Medicare fee schedule for Tennessee multiplied by 75% and inflated with expected trend values as reported by Medicare. The updated National Conversion Factor is referenced in the Federal Register on or about October 31 each year.

3. Reimbursement for therapies, medical supplies, durable medical equipment, prosthetics, orthotics, and orthodontic/dental intervention services shall be based on the American Medical Association Physicians' Current Procedural Terminology (CPT) codes relative value units and the Direct Purchase Authority for the CSS program.

4. Reimbursement for nutritional supplements, hearing aids, and hearing aid supplies shall be based on the competitive bid system as designated in the State of Tennessee purchasing procedures and the Direct Purchasing Authority for the CSS Program.

5. Non-hospital services for which there is no Medicare price shall be paid at 75% of the billed charges.

(c) No reimbursement will be paid for any covered service over 24 months old.

(6) Authorization of providers and vendors for reimbursement shall be determined in accordance with the standards as designated in these rules and determined by the program.

(7) Billing procedures for hospitals, institutions, facilities, agencies, providers, vendors, or distinct parts thereof rendering care or medical services shall be determined by the Department.

(8) No CSS provider shall charge CSS clients more than is charged for private clients for equivalent accommodations and services.

(Rule 1200-11-3-.05, continued)

(9) The CSS program is not responsible for paying for services that could have or would have been paid by private insurance or TennCare except for failure to follow their requirements.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed April 12, 1979; effective May 28, 1979. Repeal and new rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*

1200-11-3-.06 STANDARDS OF CARE.

(1) Participating physicians shall be licensed to practice medicine in Tennessee (or in the state where the service is delivered) and be certified and/or board eligible in their respective specialties. The Board of Dentistry must certify all dentists in their respective specialty. All other providers must be appropriately certified and/or licensed in their respective specialty.

(2) Physicians and dentists participating in a TennCare Managed Care Organization (MCO) network shall be recognized by the program as providers and must complete an application to the CSS program for reimbursement purposes. Physicians and dentists not participating in a TennCare MCO network must complete an application and be approved to serve as a CSS provider.

(3) All physicians and dentists must sign an agreement whereby they agree to abide by these rules and regulations and CSS program policy.

(4) Hospitals, facilities, physicians, dentists, and therapists, as well as other providers and vendors receiving payment from the CSS program for a patient, may not submit to the family of that patient, concurrent charges over and above the amount covered by TennCare, private insurance, or as provided in these rules and regulations.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed December 30, 1983; effective January 29, 1984. Amendment filed May 29, 1990; effective July 13, 1990. Repeal and new rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*

1200-11-3-.07 OUT-OF-STATE TREATMENT.

(1) Services may be provided in out-of-state facilities, with prior written approval from the CSS program director, when the following conditions are met.

(a) Evidence is provided by the referring physician that services requested are not available within Tennessee or explicit medical justification is given to prove such out-of-state treatment to be in the best interest of the child.

(b) Reimbursement for services shall be based on a negotiated rate paid by the CSS program in that state or that state's Medicaid rate, whichever is less.

(c) The out-of-state length of stay and estimated hospital charge shall be within the limits established by the program.

(d) The out-of-state estimated cost of out-patient follow-up and/or discharge services shall be equal or comparable to the Title V CSHCN rate in that state or that state's Medicaid rate, whichever is less.

(e) Tennessee's Children's Special Services Rules and Regulations 1200-11-3-.05 Authorization and Reimbursement for Services shall apply.

(2) In order to maintain continuity of care, children receiving services under these rules and regulations who move out of state shall be referred to the appropriate Title V CSHCN program within the state of new residence upon written permission of the legal guardian.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*

1200-11-3-.08 APPEALS AND CLOSURE OF CASES.

(1) Appeals

(a) Applicants who are denied participation in the Children's Special Services program, or participants who are discontinued from the program in accordance with these rules and regulations, may appeal the decision in writing to the program director within thirty (30) calendar days of receipt of the program's written notice of denial or closure. If the denial is upheld, the individual may appeal the decision in writing to the Commissioner within ten (10) calendar days of receipt of the written notice that the initial appeal has been denied. The decision of the Commissioner shall be final.

(2) Closure of Cases

(a) Cases may be closed or participants may be denied services for the following reasons:

1. participant has received maximum treatment for the eligible diagnosis;

2. participant has attained the age of twenty-one (21). Those with a diagnosis of Cystic fibrosis may remain on the program past the age of 21 years, pursuant to rule 1200-11-3-.03 (3).

3. participant moved out of state;

4. participant expired;

5. participant not diagnostically eligible;

6. participant not financially eligible;

7. participant's family not interested; or

8. participant can not be located by the Department.

Authority: *T.C.A. §§4-5-202, 68-1-103, and 68-12-101 et seq.* ***Administrative History:*** *Original rule filed March 21, 2000; effective July 28, 2000. Repeal and new rule filed October 9, 2002; effective December 23, 2002.*